USAble Life
P. O. Box 1650
Little Rock, Arkansas 72203-1650
(501) 375-7200 • 1-800-648-0271

Arkansas State Employees Life Insurance Application And Change Form

Home Office Use Only	
Eff Date	
AGENCY VERIFICATION	
Initials	

RETURN COMPLETED FORM TO YOUR AGENCY INSURANCE REPRESENTATIVE.

- ☐ New Coverage
- ☐ Beneficiary Change
- ☐ Add Dependent Life
- ☐ Employee Name Change
- ☐ Employee Address Change
- ☐ Agency Change
- ☐ Increase Supplemental Life Amount
- ☐ Decrease Supplemental Life Amount
- ☐ Increase Optional Dependent Life Amount
- ☐ Decrease Optional Dependent Life Amount
- ☐ Termination of Employment - (Date of Termination _____)
- ☐ Drop All Employee Life Coverage
- ☐ Drop All Supplemental Life Coverage
- ☐ Drop All Dependent Life Coverage
- ☐ Drop All Optional Dependent Life Coverage

APPLICANT INFORMATION

Employee Name (Last, First, M.I.)					Employee #		Group # 6730
Home Address	Street		City	State	Zip		Social Security #
Date of Birth	Birth State	Sex ☐ Male ☐ Female	Height (ft.-in.)	Weight (lbs)	Marital Status		Home Phone #
Agency Name		Agency Number		Date of Hire			Work Phone #
Complete if making an Agency Change		Old Agency Name			Old Agency Number		Eff. Date of Change

SPOUSE AND CHILDREN INFORMATION (Complete if applying for Dependent Coverage.)

List ALL Dependents To Be Covered For One Or More Unit(s) of Dependent Life Insurance.
Dependents NOT Listed Will Not Have Coverage.

Person Proposed for insurance Show first, middle, last name	Relationship	Date of Birth & Place				Height	Weight	Marital Status	Sex
		Mo.	Day	Yr.	State or Country				

SELECT YOUR INSURANCE COVERAGE

BASIC LIFE COVERAGE ($10,000 coverage PAID for by the State of AR)

I hereby apply for the following Basic Life Coverage (if not currently enrolled):

- ☐ Employee $10,000 (Paid for by State of AR)
- ☐ Legislators and Constitutional Officers $10,000 (Paid for by State of AR)
- ☐ Legislators and Constitutional Officers Basic Life of $30,000

☐ DECLINATION - I do not wish to participate/continue under the State Employees' Group Life Plan. I understand that I will have to furnish proof of good health if I apply at a later date.

SUPPLEMENTAL LIFE COVERAGE

For Employees, Legislators & Constitutional Officers

Annual Salary from State of Arkansas

$_____

I hereby apply for:

- ☐ 1 times my annual salary rounded to next higher $1,000 = $_____
- ☐ 2 times my annual salary rounded to next higher $1,000 = $_____

For Dependents of Employees	*For Dependents of Legislators & Constitutional Officers*
Unit(s)/Insurance Amount	**Unit(s)/Insurance Amount**
☐ 1 Unit - $4,000	☐ 1 Unit - $20,000
☐ 2 Units - $8,000	☐ 2 Units - $40,000
☐ 3 Units - $12,000	
☐ 4 Units - $16,000	
☐ 5 Units - $20,000	

BENEFICIARY DESIGNATION /CHANGE

This will revoke any existing beneficiary designations you may have under these benefits.

Name (Last, First, MI)	Address	Birth Date	Relationship	Primary or Secondary	Percentage Distribution*

* Death Proceeds will be paid to the Primary Beneficiary(ies) if living, otherwise as specified above to the Secondary Beneficiary(ies).

PLEASE COMPLETE AND SIGN REVERSE SIDE.

MEDICAL INFORMATION

Note: This information is only needed when adding or increasing coverage.
Complete the information below on all persons applying for coverage (applicant and/or dependents).

1. Have you, your spouse or children been hospitalized for any reason during the past five (5) years? ❑ Yes ❑ No
If yes, give date, name of person(s), and reason hospitalized:

2. Have you, your spouse or children consulted a physician in the past one (1) year? ❑ Yes ❑ No
If yes, give name of person(s), names of doctors seen, and reason:

3. Have you, your spouse or children ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? ❑ Yes ❑ No If yes, list name of person(s), medications taken, medication dosage, and last two blood pressure readings.

4. Have you, your spouse, or children ever been diagnosed by or received treatment from a member of the medical profession for:

		Yes	No			Yes	No
a)	Cancer or any cancer related disease?	❑	❑	e)	Alcohol or Drug Abuse?	❑	❑
b)	Disease of the heart or blood vessels, or had a stroke?	❑	❑	f)	Lung, Liver or Blood Disorder	❑	❑
c)	Kidney disease or diabetes?	❑	❑	g)	Emotional, Nervous System or Mental Health Problems?	❑	❑
d)	AIDS or AIDS Related Complex, Immune Deficiency Disorder, or tested positive for antibodies to HIV?	❑	❑				

GIVE DETAILS TO ANY "YES" ANSWERS TO QUESTION 4 above, including name of person, diagnosis, and dates of treatment:

5. Do you, your spouse or children have any impairments, diseases or illnesses not covered in questions 1 through 4?
❑ Yes ❑ No If yes, give details, including name of person, diagnosis, and dates of treatment:

6. Are you, your spouse or children currently taking medication(s)? ❑ Yes ❑ No If yes, give name of person, medication(s), dosage, and reason for taking medication(s):

7. Name, address, and phone number of personal physician(s):

8. Have you, your spouse or children ever been declined coverage under this Plan? ❑ Yes ❑ No Any other plan? ❑ Yes ❑ No

AUTHORIZATION SECTION

In signing below, I (a) represent that the statements and answers given in this application, both front and back, are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc., having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid for two (2) years from the application date; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (f) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act; and (g) acknowledge receipt of the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

Insurance Fraud Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

DATE OF APPLICATION _____ _____
MONTH/DAY/YEAR EMPLOYEE'S SIGNATURE

RETURN COMPLETED FORM TO YOUR AGENCY INSURANCE REPRESENTATIVE.

USAble Life

P.O. Box 1650
Little Rock, AR 72203

NOTICE FOR PROPOSED INSURED

Notice of Insurance Information Practices
In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

Insurance Fraud Warning
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

Federal Fair Credit Reporting Act Notice
In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

Medical Information Bureau Disclosure Notice
Information regarding your insurability will be treated as confidential. USAble Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (Bureau), a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Tel. (617) 426-3660.

USAble Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.